The Sydney children's Hospitals Network
care, advocacy, research, education

DESTRUCTION OF SCANNED HEALTH CARE RECORDS

POLICY©

DOCUMENT SUMMARY/KEY POINTS

- This document outlines how the SCHN Health Information Services comply with guidelines for disposing of paper health care records after document imaging (or scanning).
- This policy ensures compliances with the State Records General Disposal Authority: Imaged Records (GA 45)
- Ensures compliances with Interim Australian Standards Health Records: Part 2: Digitized (scanned) health record system requirements.

CHANGE SUMMARY

- SCHN version was due for review with a change of retention period post scanning.

READ ACKNOWLEDGEMENT

- SCHN Health Information Unit Management Team and the SCHN Health Information (Medical Records) Administrative Officers must read and acknowledge they understand the contents of this policy.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st May 2017	**Review Period:** 3 years
Team Leader:	Manager	**Area/Dept:** Medical Records, SCHN

This Policy/Procedure may be varied, withdrawn or replaced at any time. Compliance with this Policy/Procedure is mandatory.

Background

SCHN health records strategy aims to ensure a single patient view of records in a reliable and accessible electronic medical record across the Network. The progression to direct entry Health Care Records is part of the overarching MEMORY Strategy. .

The Sydney Children's Hospital Network comprising of Children's Hospital at Westmead (CHW), Sydney Children's Hospital, Randwick and the Newborn and Paediatric Emergency Transport Service (NETS) scans health care records using the Clinical Record Information System (CRIS). This means that when 'loose' sheet paper health care records are returned to the Health Information Unit (HIU), they are put through the document imaging processes making all information part of the patient's Electronic Medical Record (eMR). Currently CHW patient health care records staff access these via the CHW eMR. For SCH patient scanned health care records staff access these via the SESI eMR. For NETS patient scanned health care records staff access these via CHW eMR or at the NETS database (pre-2017).

Process

Documents are imaged into the Clinical Record Information System (CRIS) at the end of each encounter by the Health Information Unit (HIU).

Document Imaging Processes involve 3 procedures, prepping (ensuring all documents are ready to be fed into the scanner) scanning (quality checking documents once they have been scanned) and indexing (itemising each document or health care form for ease of review). Final process after set quality checks includes the secure destruction of these records.

Health Care Records documents that have been scanned are available to view by authorised staff through both the SESI eMR and the CHW eMR. Scanned records are considered a true record and can be retained as an alternate to the paper form, allowing the original paper record to be destroyed.

Compliance with State Records General Retention and Disposal Authority: Imaged Records (GA 45)

The "General Retention and Disposal Authority: Imaged Records"[1] (GA45) issued by State Records provides authorisation for the destruction of patient/client records that have been copied into a digital format.

The Authority provides authorisation for the destruction of the originals of health care records that have been imaged provided that the following conditions have been met:

- **All requirements for retaining originals have been assessed and fulfilled**.

  Notes that have been scanned are available in an electronic format which is retained permanently by SCHN This is supported by NSW Ministry of Health and the Evidence Act (1995) which states that it "does not preclude electronic records being used as evidence unless their veracity can be questioned, making electronic records legally acceptable. This is also supported in the Authority[1] which states, "Where an original State record is legally destroyed, the imaged copy becomes the official State record".

- **Copies are made which are authentic, complete and accessible**.

  SCHN meets the requirements set out in the Authority[1]:

To be:	…an image copy must be
Authentic	the product of routine, authorised copying and registration processes
Complete	an accurate, legible reproduction of the original, in its entirety
Accessible	Available and readable to all those with a right to access it, for as long as it is required

- Prior to commencing imaging and disposal of imaged health care records appropriate approval from State Records was obtained. Processes for imaging and managing images as records are documented in the Document Imaging Procedure Manual.
- **Copies are kept for the authorised retention period**, and

  As outlined in the Authority[1], "where an original State record is legally destroyed, the image copy becomes the official State record". The electronic copy of the records will be retained for the full retention period required for paediatric medical records with appropriate measures to ensure their accessibility over time.

- **Originals are kept for quality control purposes for an appropriate length of time after copying**.

  Original paper notes are retained for a period of at least one (1) week post Document Imaging processes. State Records recommends a minimum retention period of six months, however recognises that periods of one to three months may be appropriate for low risk records.

  SCHN suggests that retention of paper records for one week is appropriate due to the quality assurance systems in practice.

  - Regular quality checks are performed by the SCHN Document Imaging Team on documents which are scanned and committed to CRIS.
  - SCHN Document Imaging Team monitor the CRIS Quality Assurance log as well as works on annual audits.
  - One health care document is passed through the 3 processes (prep, scan and index).

- Prior to any destruction, notes are placed systematically into archive boxes and retained for one week.
- Original health care record notes will not be released by the Health Information Unit, once they have been imaged and available in the eMR. For medico legal requests the imaged health care record will be extracted and and made available via electronic format/paper format as requested.

SCHN can currently confirm that:

SCHN complies with the processes as described in General Retention and Disposal Authority: Imaged Records (GA45)

Destruction of SCHN Health Care Records

Imaged Health Care Records are confidentially destroyed in accordance with the Health Records and Information Privacy Act 2002 and State Records' guidelines. Destruction of the original documents occurs one week post imaging. The notes are destroyed following strict protocols.

All documents are available in the scanning system. CRIS can be electronically tracked via extensive audit reports that are available in the Native CRIS application. Audit reports can be requested from the SCHN Health Information Service Manager or the Health Information Manager at each campus. Prior to the destruction of any notes, administrative officers at CHW and SCH please refer to the Destruction Procedure in the Health Information Procedure Manual which can be accessed by contacting the SCHN Health Information Service Manager on 984 52356. For Newborn and paediatric Emergency Transport Service the Destruction Procedure can be accessed by contacting 9633 8700.

References

1. General Retention and Disposal Authority: Imaged Records (GA45)
2. Document Imaging Procedure manual (access provided by contacting SCHN Health Information Service Manager) or respective CHW, SCH or NETS Health Information Units)

Copyright notice and disclaimer:

The use of this document outside Sydney Children's Hospitals Network (SCHN), or its reproduction in whole or in part, is subject to acknowledgement that it is the property of SCHN. SCHN has done everything practicable to make this document accurate, up-to-date and in accordance with accepted legislation and standards at the date of publication. SCHN is not responsible for consequences arising from the use of this document outside SCHN. A current version of this document is only available electronically from the Hospitals. If this document is printed, it is only valid on the date of printing.